Background

Chronic diseases represent 63% of all deaths worldwide. Against the background of demographic aging, the prevalence of comorbidity or multi-morbidity is as high as 60% among individuals aged 55 to 74 years. In the context of the resource-challenged environment in the Global South and the financial crunch wrought by the financial crisis in the global North, the financial and non-financial burden of chronic diseases make their management a priority concern globally. Primary care plays a critical role in dealing with this epidemic.

To harness the full potential of primary care, however, the way it is organized needs transformation. At present:

1. primary care is still organized around the general practitioner even as the shortage of primary care physicians is worsening and is unlikely to improve in the immediate future;
2. models of care for the chronically ill are directed to the management of each disease separately, and focus on the treatment of the individual patient;
3. The health care system fails to harness the contribution of patient self-management even as role of patient involvement in their health and health care is recognized; and
4. Sectors within the system continue to operate in silos and default to traditional boundaries and turf battles even as technologies allow interface.

These challenges are true for primary care in low and middle-income settings and high-income settings. A global framework for the transformation of primary care, consequently, offers promise to every health care system. The critical elements of such involve:

From “Care Groups” for individual conditions...

In the Netherlands, chronically ill patients can be cared-for by so-called “care groups”, which are multi-disciplinary arrangements among providers and between sectors contracted with health insurers on the basis of a bundled payment for a defined package of services defined by national standards for a selection of chronic diseases. Initially developed for Type 2 diabetes (DM2), care groups have been developed for vascular risk, chronic obstructive pulmonary disease, heart failure. Contracts differ in the extent to which they offer additional services beyond the core package of care.

Patients are enrolled into care groups via the general practitioner (GP) they are registered with. The GP acts as central coordinator, supported by practice and specialized nurses responsible for care management. Following the 2009 amendment of the 1993 Individual Health Care professions, clinical nurse specialists are allowed to perform common and minor medical procedures and thus play a pivotal role in the care of the chronically ill and the elderly.

The level of need of each individual patient enrolled defines the spectrum and magnitude of services delivered which include self-management education. In keeping with the gatekeeping role of the GP in the Dutch health care system, the GP oversees any referrals to secondary care according to defined criteria and ensures follow-up. To facilitate the patient pathway, check-up and referrals data within the care program are stored in a disease-specific electronic patient record (‘MediX’) which allows for information sharing and automation of care protocols.

...To medical homes for various conditions

The focus on single diseases at present is a limitation given the often multiple health problems among people with chronic conditions. In this regard, and in light of the management standard developed for children and adults with obesity, the integration of such with that for DM2 and CVD is currently underway and is expected to be completed by the end of 2012. As can be seen in Figure 1, the effective management of obesity goes hand-in-hand with the management of DM2 and CVD.

References:

Siedel JC et al. An integrated health care standard for the management and transition of primary care, which in turn impacts on the sustainability of the health care system or the affordability, acceptability and accessibility of health care. Building on initial, partial successes and learning from the shortcomings of previous efforts should make the difficult task manageable and foreseeable.

Fig. 1. Classification of weight-related health risks

<table>
<thead>
<tr>
<th>BMI kg/m²</th>
<th>Increased risk for DM2 and CVD*</th>
<th>Co-morbidities</th>
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</thead>
<tbody>
<tr>
<td>&lt; 25 BMI &lt; 30</td>
<td>Moderately increased</td>
<td>Moderately increased</td>
</tr>
<tr>
<td>≥ 30 BMI &lt; 35</td>
<td>Moderately increased</td>
<td>Severely increased</td>
</tr>
<tr>
<td>≥ 35 BMI &lt; 40</td>
<td>Severely increased</td>
<td>Very severely increased</td>
</tr>
<tr>
<td>BMI ≥ 40</td>
<td>Very severely increased</td>
<td>Very severely increased</td>
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</tbody>
</table>

* 5% increased mortality risk of CVD and increased risk assessed by a type 2 diabetes mellitus (DM2) risk score which includes waist circumference, family history of DM2, the presence of hypertension, physical inactivity as well as the diagnosis of impaired fasting glucose.

** DM2, CVD, sleep apnea and/or arthritis

Source: Siedel et al. 2012

The system could do better, however, by being ready to deal with patients who have two or more chronic conditions – or are multimorbid. To do so, the GP practice may well leverage the availability of several other providers under one roof in considering the “guided care model” as a component of a medical home approach in the delivery of health care. The development of independent treatment centers, which are specialized institutions in one type of care independent of hospitals, can likewise be leveraged in terms of cooperating.

As in the development of the care groups, incentives both financial and regulatory, would be crucial in the further transformation of primary care, which in turn impacts on the sustainability of the health care system or the affordability, acceptability and accessibility of health care. Building on initial, partial successes and learning from the shortcomings of previous efforts should make the difficult task manageable and foreseeable.

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